pennsylvania
DEPARTMENT OF HUMAN SERVICES

OFFICE OF DEVELOPMENTAL PROGRAMS BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
June 28, 2022	July 1, 2022	00-22-03

SUBJECT	BY
Technical Guidance for Claim and Service Documentation	Kristin Ahrens, Deputy Secretary for Developmental Programs

SCOPE:

Administrative Entity Administrators or Directors
Agency With Choice Financial Management Services
Common-Law Employers in the Vendor/Fiscal Employer Agent Financial Management Services Model
County Mental Health and Intellectual Disability Administrators
Supports Coordination Organizations
Base-Funded Supports Coordination Providers
Providers of Targeted Support Management
Providers of Consolidated, Community Living, Person/Family Directed Support (P/FDS), and Adult Autism Waiver Services and Providers of Base Services

PURPOSE:

The purpose of this bulletin is to provide guidance on documentation needed to substantiate a claim and guidance on the service documentation processes. This guidance is applicable to providers and Supports Coordination Organizations (SCO) that render services through the Consolidated, Community Living, P/FDS, and Adult Autism Waivers as well as Targeted Support Management (TSM) and base-funded services.

BACKGROUND:

The Department of Human Services (DHS) uses claim and service documentation to verify that the services billed to DHS are delivered to the individuals approved to receive the services and are delivered in accordance with state and federal standards. Section 2497.2 of the Centers for Medicare and Medicaid Services' (CMS) State Medicaid Manual requires accounting records to be supported by appropriate source

documentation and be readily available for audit. There are federal and state requirements regarding the type of documentation that must be available at the time of claim submission. To ensure that all federal and state requirements are met, providers must maintain the documentation used to generate a claim. If the provider does not have this documentation, the claim is not eligible for Federal Financial Participation (FFP).

Pennsylvania requirements in 55 Pa. Code Chapter 1101 (relating to general provisions) specify the documentation requirements for clinical services for the treatment of a medical diagnosis. Providers of home and community-based services are required to comply with Chapter 1101.

The minimum standards for documentation that is needed in order to substantiate a claim are addressed in 55 Pa. Code § 6100.226 (relating to documentation of claims). Some services require additional documentation to support a claim based on the service definitions within each of the approved Waivers.

The minimum requirements for the completion of progress notes are addressed in 55 Pa. Code § 6100.227 (relating to progress notes). A progress note is completed at least every three months and requires an evaluation of whether the activities occurring as part of the provision of home and community-based services are helping the individual achieve the individual's desired outcomes as stated in the Individual Support Plan (ISP). Because a progress note is completed after the provision of services, it does not have to be completed prior to the submission of a claim for payment. Progress notes must be maintained as part of the individual's record. Some services require additional documentation to support service delivery based on the service definitions within each of the approved Waivers.

DISCUSSION:

Documentation to provide a record of services delivered to an individual must be prepared and kept by the provider, SCO, or common-law employer for the purposes of substantiating a claim and documenting service delivery. The Office of Developmental Programs (ODP) has developed Technical Guidance for Claim and Service Documentation (Attachments 1 and 2), which provides specific guidance for providers and SCOs on the documentation that must be kept for each service in order to support a claim and to document service delivery. These attachments apply to services rendered by providers and SCOs that have enrolled directly with ODP, organized health care delivery systems, and services delivered through both self-directed services models, Agency with Choice and Vendor Fiscal/Employer Agent.

I. Service Notes

One major component in supporting a claim is service notes.[1] The service note is completed the same day that services are rendered and is used to document the provision of a service and the activities that occurred that day. Service notes are to be

[1] The service note was previously referred to as an Encounter Form for Adult Autism Waiver services.

used by provider staff, the provider, the common-law employer/managing employer, and the Supports Coordinator information about services provided and can help providers render high quality services. Service notes may be reviewed by ODP, Administrative Entities (AE), and SCOs to verify that services are being delivered as required in the ISP. ODP strongly recommends that each service note also include the goals and outcomes identified in the ISP that were worked on during the provision of service. Service notes are also designed to help the provider prepare and complete a high-quality progress note (as described on page 8 of this bulletin).

In accordance with 55 Pa. Code § 6100.226(b), providers must comply with the following requirements for service notes for services billed in **hour or 15-minute units**:

- A service note must be completed for each continuous span of billing units. A continuous span of billing units is defined as the provision of a service by the same staff person that is not stopped or discontinued. A new service note must be completed if there is an interruption in service and the service is reinitiated within that same calendar day or if there is a change of staff person providing the service within the calendar day and the service is reinitiated within that same calendar day.[2]
- The service note must be completed by the person providing the service.[3]
- A service note must be completed on the day the service is delivered.[4] It is best practice to complete the service note during or immediately after the provision of a service. For example the service note could be completed near the end of a staff person's shift or after the staff person assists the individual with a community activity. Service notes can also be started at the beginning of a shift and worked on throughout the staff person's shift, but staff must make sure to complete the service note on the day the service was rendered.
- If an individual is receiving multiple services throughout the day and the services are rendered by the same staff person, service notes may be entered in the same document or form if all required information is included for each service.

In accordance with 55 Pa. Code § 6100.226(b), providers must comply with the following requirements for service notes for services billed **in day units**:

- A service note must be completed for each day unit that documents the provision of direct or indirect services (such as staff on-call or the use of remote monitoring) for the minimum number of hours required to bill for the day unit. A

[2] Exceptions to the completion of a new service note when there is a change in staff person exist for Community Participation Support and Day Habilitation services delivered in a facility-based setting. See Attachments 1 and 2 for guidance.

[3] In facility-based or residential settings, a supervisor or program specialist who is present for the entirety of the service provision on the day services were delivered can complete the service note based on their observations of service delivery and staff reports about the activities that were provided to or on behalf of the individual.

[4] Exceptions to the requirement that the service note be completed on the day the service was delivered will be made for extraordinary circumstances or emergencies when the provider documents the extraordinary circumstance or emergency and why it precluded a service note from being completed on the day the service was delivered. Supports Coordinators and Targeted Support Managers have one business day to document service delivery, as described on page 7 of this bulletin.

new service note is not needed if there is an interruption of the service within a calendar day and the service is reinitiated within that same calendar day.

- For residential services (Residential Habilitation, Life Sharing and Supported Living) or Respite services provided in licensed or unlicensed residential settings or other licensed settings (private ICFs/ID or nursing homes), a service note must be completed for each day unit that documents the provision of at least 8 hours of support.
- For Out-of-Home Respite services provided through the Adult Autism Waiver, a service note must be completed for each day unit that documents the provision of 10 or more hours of support.
- For Respite services provided in private homes that are billed as a day unit, a service note must be completed for each day unit that documents the provision of more than 16 hours of support.
- A service note must be completed on the day the service is delivered.[5]
- The service note must be completed by the person providing the service.[6]
- When there is a change in staff providing a service that is billed in day units, a new service note is not required. It is best practice when there is a staff change during the provision of services that staff communicate with each other so that the service note will have information from the entire time that services were rendered.
- The amount of time the individual is not in the setting where the individual is receiving services is not required to be included in the service note, but a provider may choose to include this information.
- Multiple service notes for one individual may be entered in the same document or form if all required information is included. For example, if a provider chooses to have multiple staff persons in a residential setting each write a description of activities the staff person completed with the individual, all of those descriptions could be recorded in one document.

In accordance with 55 Pa. Code § 6100.226(c), all service notes must include, at a minimum:

- **Identifying information for the individual.** The following will be accepted: Individual's full name (first and last), the individual's Master Client Index (MCI) number, or the individual's Medical Assistance (MA) number.
- **Identifying information for the provider.** The following will be accepted: The provider agency's name or the provider agency's 9-digit Master Provider Index (MPI).
- **The date of the service delivery.**

[5] Exceptions to the requirement that the service note be completed on the date the service was delivered will be made for extraordinary circumstances or emergencies when the provider documents the extraordinary circumstance or emergency and why it precluded a service note from being completed on the day the service was delivered.

[6] In facility-based or residential settings, a supervisor or program specialist who is present for the entirety of the service provision on that day services were delivered can complete the service note based on their observations of service delivery and staff reports about the activities that were provided to or on behalf of the individual.

- **Identification of the service delivered.** The name of the service or 5-digit procedure code are both acceptable.
- **The date the documentation is completed.**
- **The name and signature of the person completing the documentation.** The person completing the service note must sign the service note. It is not acceptable to sign service notes weekly or initial service notes. If multiple service notes from the same staff person for the same calendar day are captured on one document, the staff person only needs to print their name and sign the document once. Electronic signatures are acceptable.
- **The name of the staff person who delivered the service if the staff person who delivered the service is different than the staff person completing the service note.** For services delivered in a facility-based setting or if there is a staff ratio greater than 1:1, it is recommended that the provider identify the names of all staff persons who delivered services in the service note. If the provider chooses not to identify the names of all staff person who delivered services in the service note, the provider must have other supporting documentation that identifies who delivered services. For example, a provider could have time sheets or scheduling documents that identify which staff were in the facility or the activities in which staff were involved.
- **The place the service was delivered.** If the location where the service was delivered is inherently clear in the description of activities, there is no need to list the place the service was delivered separately in the service note.
- **The number of units of service delivered.** For services billed in hour units or 15-minute units and day unit Respite, the start time and end time of when services were delivered must be documented in the service note in order to determine the number of units delivered and substantiate the claim. Because start and end times are documented, service notes do not have to include the number of units of service delivered.[7] For Residential Habilitation, Supported Living, and Life Sharing services the provider is not required to document start and end times for the delivery of services or the number of units of services delivered.
- **The nature or description of the activities involved in the service.** The service note must identify the assistance, support, or guidance provided, which are consistent with the individual's goals identified in the ISP and the Waiver service definitions. The nature or description of the activities involved in the service must include enough detail to substantiate the amount of time billed for that service. It is recommended that the service note also include a description of any activities that were offered during service delivery but declined by the individual.

[7] SCOs, Base-Funded Supports Coordination providers, and TSM providers must document start and end times of when services were delivered and number of units delivered. Further guidance related to documenting start and end times and number of units can be found on page 7 of this bulletin.

Checklists in Service Notes that Document the Nature or Description of the Activities

As described in the last bullet above, each service note must include the nature or description of the activities involved in the provision of the service. For some services, providers may choose to create and use a checklist to document the activities provided to or on behalf of the individual. Services that are allowed to use a checklist to meet this requirement are defined in Attachments 1 and 2.

When a checklist is allowed and used, a separate service note is not required as long as the checklist includes all of the information required by 55 Pa. Code § 6100.226(c) and as described above.

Checklists may be developed broadly based on the service definition of the service or specifically for the individual being served. When developed broadly, the list of things that can be "checked off" on a provider's checklist are full or abbreviated descriptions of activities as described in the service definitions. Examples of checklists based on service definition are included in Attachments 1 and 2.

When a checklist is allowed, the checklist satisfies the requirement for the service note to include the nature or description of activities. A narrative of activities in addition to a checklist is not required but may be helpful because checklists alone do not capture anecdotal information from direct support professionals. Providers considering the use of a checklist should consider the following:

- Can a checklist meet the provider's documentation needs?
- Will the use of a checklist provide enough information to determine if the quality of the service provided meets the provider's expectations?
- Will the use of the checklist provide adequate documentation on the individual's level of assistance, support, and guidance needed to enable the provider to evaluate an individual's progress towards a goal and develop a high quality progress note?
- Should a narrative in addition to a checklist be used by direct support professionals?

The following are examples of checklists that are unacceptable because they do not meet the requirements for claim documentation included in 55 Pa. Code § 6100.226:

- The checklist only lists the name of the service and does not describe any activities that occurred during service delivery.
- The checklist includes a description of activities that are not included in the service definition.
- The checklist includes the delivery of activities that are not compensable.
- The checklist does not support the amount of time billed on the claim.
- The checklist solely includes a list of outcomes or goals and does not include an additional description of the activities that were performed during service delivery. For example, "improve social skills" may be an outcome or goal for an individual but does not describe the activity that occurred to work towards that outcome or goal.

Service notes are not required to be completed for every service. The claims for some services are satisfied by an invoice, receipt, or other documentation. Attachments 1 and 2 specify the requirements for each service. When service notes are required, they must be completed as specified in this bulletin regardless if the service was delivered in-person or using remote technology when permitted.

When an individual is self-directing services through the Vendor Fiscal/Employer Agent model, the common-law employer is responsible for ensuring that service notes are completed. The service notes shall be maintained in the individual's record by the common-law employer. When an individual is self-directing services through the Agency with Choice model, the managing employer, or if necessary, the Agency with Choice organization will ensure that service notes are completed. The service notes shall be maintained in the individual's and Agency with Choice organization's records.

Supports Coordination Organizations, Base-Funded Supports Coordination Providers, and Targeted Support Management Providers

Due to the nature of the delivery of this service, Supports Coordinators and Targeted Support Managers must document service activities that occur with or on behalf of individuals within one business day of the activity. Documentation of service activities may be in any form (for example, logs, electronic notes, and other recorded documentation completed during provision of services) as long as it has sufficient information to complete the Home and Community Services Information System (HCSIS) service notes. SCOs, Base-Funded Supports Coordination providers, and TSM providers have 7 days[8] from the date of contact with the individual to enter their service notes into HCSIS.

The HCSIS service note must include all information necessary to substantiate a claim. SCOs, Base-Funded Supports Coordination providers, and TSM providers can determine which of the following ways they want to document the start and end time of each service provided:

- Using the start and end time field in HCSIS;
- In the body of the text of the service note in HCSIS; or
- On the documentation that is completed within one business day of the activity.

The documentation of service activities that occur with or on behalf of individuals that was completed within one business day of the activity does not need to be maintained if all elements required in a service note, including start and end time for each service provided, is included in the HCSIS service note. If the start and end times are not included in HCSIS, the documentation that verifies the start and end times for the service must be maintained in accordance with 55 Pa. Code § 6100.54 (relating to recordkeeping) and must be available for review to substantiate a claim. If a person other than the Supports Coordinator or Targeted Support Manager who rendered the service completes the HCSIS service note, the SCO, Base-Funded Supports

[8] This is a new requirement for SCOs providing services through the Adult Autism Waiver. The previous timeframe was 14 days.

Coordination provider, or TSM provider must retain the documentation that verifies the service activities that occurred and who rendered the activities.

In addition to start and end times, SCOs, Base-Funded Supports Coordination providers, and TSM providers must document the number of units in the "service note/billable claim details" screen in HCSIS for each service note.

SCOs, Base-Funded Supports Coordination providers, and TSM providers may enter multiple service notes as a single entry in HCSIS for services delivered to the same individual, by the same Supports Coordinator or Targeted Support Manager, on the same calendar day. When entering multiple service notes as a single entry, the start and end times of each service provided must be documented in the text of the service note in HCSIS or on the documentation of activity completed within one business day. When choosing "location of service," "service type," "category," and "sub-category" on the Service Note screen in HCSIS, the SCO, Base-Funded Supports Coordination provider, or TSM provider should choose the response that was most prominent during the time span of service delivery.

II. Progress Notes

The requirements for progress notes are described in 55 Pa. Code § 6100.227 (relating to progress notes). Progress notes[9] are typically written by a program specialist or other provider staff who conducts routine reviews or oversight of staff or during service monitoring. To formulate a progress note, the person preparing the progress notes must review service notes, observe service delivery, and speak with the individual, person(s) designated by the individual, and staff involved with the individual as appropriate. Since a progress note is completed after the provision of services, it does not have to be completed prior to the submission of a claim. Progress notes must be maintained as part of the individual's record.

Progress notes provide information that ODP, the AE, the Supports Coordinator or other reviewers to ensure services are meeting the individual's needs. A progress note is completed at least every three months and is used to evaluate whether the activities occurring as part of the provision of home and community-based services are helping the individual achieve the individual's desired outcomes as identified in the ISP. Progress towards an outcome or goal should be discussed with the ISP team during the annual ISP meeting or more often, as needed.

The completion of progress notes is also critical to the Quality Assessment and Improvement (QA&I) process as progress notes provide essential information for providers to review and use for self-monitoring to ensure services are rendered as authorized in the individual's ISP. As required by 55 Pa. Code § 6100.42 (relating to monitoring compliance), 6100.54 (relating to recordkeeping), and 6100.227(a) (relating

[9] The Adult Autism Waiver previously referred to progress notes as Quarterly Summary Reports (QSR). QSRs will now be referred to as Quarterly Progress Notes (QPNs). Monthly Progress Notes (MPNs) are no longer required.

to progress notes), providers, common law employers or managing employers must make progress notes available to ODP, AEs, Supports Coordinators or Targeted Support Managers, upon request. Providers in the Adult Autism Waiver must continue to follow the previously outlined timelines and process for quarterly reporting including submission to the Supports Coordinator via QuestionPro.[10]

PROGRESS NOTE TIMEFRAMES

A. Consolidated, Community Living, P/FDS Waivers and Base Funded Services

The provider must complete a progress note that covers a time period that does not exceed three months. The provider has one month after the last date included in the timeframe under review to complete the progress note. For example, if the time period of service delivery that will be included in the progress note is June 16th through September 16th, the provider has until October 16th to complete the progress note.

Progress notes must cover all dates. For example using the dates discussed above, because the last date covered by the progress note was September 16th, the period under review for the next progress note must begin on September 17th, even if the service was not delivered on September 17th.

Providers may choose to complete progress notes more frequently than every three months (i.e. once a month or twice a month). A progress note cannot cover more than a three month period. If the review dates are not convenient, a provider may want to consider shortening one of the time periods under review so that the review dates are convenient for the provider. For example, if provider ABC begins to deliver services to an individual on March 15th, provider ABC may decide to complete a progress note that covers the period of March 15th through March 31st, and complete a progress note every three months thereafter. When determining a schedule for completing progress notes, providers should consider the number of individuals they serve and the number of staff they have assigned to complete progress notes.

For services that are initiated on or after October 5, 2019, the progress note needs to cover the first date service was rendered and billed and the following three months, or more frequently if the provider chooses. For services that were initiated prior to October 5, 2019, the time period covered by the progress note begins on the day following the end date of the previous progress note.

B. Adult Autism Waiver

Providers of Adult Autism Waiver services must continue to follow previously outlined timeframes for reporting quarterly progress. Providers should continue to refer to the Adult Autism Waiver QSR Due Dates chart found on MyODP. The chart specifies the quarter under review based on the individual's Plan Effective Date and the date by which quarterly progress note must be completed and submitted into QuestionPro.

[10] Additional resources for Adult Autism Waiver providers can be found on MyODP.org.

Providers will be compliant with 55 Pa. Code § 6100.227(a) as long as they are following the timeframes defined in the chart. A progress note must be submitted for every quarter in which services are delivered.

Monthly Progress Notes (MPNs) are no longer required.

CONTENT OF PROGRESS NOTES

In accordance with 55 Pa. Code § 6100.227(c), progress notes must include the following:

(1) If the service was provided in accordance with the individual plan.

- Progress notes do not need to include every time services were not provided as specified in the ISP. For the purpose of a progress note, services should be considered to be delivered in accordance with the ISP unless there is a pattern of services not being delivered during the period under review. If the Progress Note identifies a pattern of services not being delivered as identified in the ISP, the provider should consider whether it has impacted the provider's ability to meet the needs and preferences of the individual; the individual's progress with outcomes/goals for service delivery; and the individual's health, safety, well-being, preferences, and routine.
- Determination of whether services were provided in accordance with the ISP includes consideration of the implementation of the communication strategies and progress made towards the communication goals or outcomes for individuals who have functional communication impairments. Specific guidance on progress note requirements when an individual has communication goals or outcomes in their ISP can be found in ODP Bulletin 00-08-18, *Communication Supports and Services,* or its successor.

(2) If the service met the needs and preferences of the individual.

(3) How progress will be addressed, if there was lack of progress on a desired outcome.

- If it is determined that the individual is not making progress towards the individual's desired outcomes or goals, the provider must identify why there is a lack of progress and document in the progress note the action steps the provider will take to address the lack of progress. Actions may include, but are not limited to, changing the way the service is being delivered, retraining staff on delivery of service, or requesting an ISP team meeting to discuss and address the reasons for lack of progress or whether outcomes or goals need to be revised.

(4) Impact on the individual's health, safety, well-being, preferences and routine.

In accordance with approved Waivers, ODP also requires documentation of restrictive procedures usage as part of the progress notes when restrictive procedures are included in an individual's ISP and Behavioral Support Plan.

In addition to the above, and in order to verify that progress notes were completed timely as well as satisfy basic principles for documenting a service, each progress note must include:

- **Identifying information for the individual.** The following will be accepted: Individual's full name (first and last), the individual's MCI number, or the individual's MA number.
- **Identifying information for the provider.** The following will be accepted: The provider agency's name or the provider agency's 9-digit MPI.
- **The service and date range of services under review;**
- **The name of the staff person completing the progress note; and**
- **The date the progress note is completed.**

When an individual is self-directing services through the Vendor Fiscal/Employer Agent model, the common-law employer is responsible to ensure the progress notes are completed. The progress notes shall be maintained in the individual's record by the common-law employer. When an individual is self-directing services through the Agency with Choice model, the managing employer, or if necessary, the Agency with Choice organization will complete the progress notes. The progress notes shall be maintained in the individual's and Agency with Choice organization's records.

Progress notes are not required for all services. When progress notes are not required, service notes or other documentation satisfies the progress notes requirements for 55 Pa. Code Chapter 6100. Column 3 of Attachments 1 and 2 specifies which services need progress notes.

III. Other Required Documentation

Providers must document information such as issues that impact the individual's health, safety, preferences, priorities, and routine because it is critical to the provision of services and will be reviewed by DHS or its designee when services are monitored or when claims are reviewed. In addition, licensed providers must maintain documentation in accordance with licensing regulations.

Providers must bill using the procedure codes that correspond with their Approved Program Capacity (APC). Providers need to maintain their Approved Program Capacity and Noncontiguous Clearance Form and provide it for review upon request. The Approved Program Capacity and Noncontiguous Clearance Form is needed for the following services in the Consolidated, Community Living, or P/FDS Waivers or base funding: Licensed or Unlicensed Residential Habilitation, Licensed or Unlicensed Life Sharing, Supported Living (for reserved capacity), Respite Only Homes and Licensed Community Participation Support Facilities.

When applicable, the Consolidated, Person/Family Directed Support and Community Living Waiver Variance Form (DP 1086) must be retained by the provider and must be provided for review upon request.[11]

Providers that receive the Enhanced Communication Rate must maintain the Enhanced Communication Rate Request Form, its attachments, and the formal notice of approval from ODP in the individual's file and must provide these documents for review upon request.

In addition to the above, Attachments 1 and 2 specify for each service the other documentation that must be maintained in the record to support a claim and meet standards for service delivery.

IV. Review of Claim and Service Documentation

Providers and SCOs are responsible for reviewing their own claims for Waiver and base-funded services, as applicable, as part of their internal controls, QA&I self-assessment, and during the provider's independent audit. Further, licensed and unlicensed providers must develop policies and procedures that include safeguards to demonstrate compliance with CMS assurances, including CMS expectations regarding state efforts to prevent fraud, waste, and abuse.

If a provider or common-law employer discovers that any part of the required documentation is not present or does not include all of the required elements, the provider or common-law employer must act to remediate the situation to avoid reoccurrence. The type of remediation needed must be determined on a case-by-case basis and whether the finding of non-compliance was an isolated or systemic issue should be taken into consideration.

Review of claims and service documentation occur as part of the QA&I process or as a result of a complaint. In addition, the Bureau of Financial Operations (BFO) may review claims and service documentation in accordance with their policies and procedures. During any review or audit, the provider must provide documentation that substantiates the claim in accordance with this bulletin and appendices. If it is discovered that a provider is non-compliant with federal or state regulations or ODP waivers or policies during a review of claim and service documentation, the provider or common-law employer (through the common-law employer agreement) may be subject to sanction or remediation.

If any number of claims comes into question, the review may be expanded. This may be done through a review of records obtained from the provider or an on-site visit. The scope and protocol will be determined based on the situation and data source.

[11] In the Adult Autism Waiver, this form is called the Exception to Established Service Limits form.

V. Sanctions and Remediation[12]

In accordance with 55 Pa. Code §§ 6100.741 (relating to sanctions) and 742 (relating to enforcement), ODP has the authority to enforce compliance with 55 Pa. Code Chapter 6100 using an array of sanctions including recouping, suspending, or disallowing payment.

1. Regardless of how the problem with a claim is identified or by whom it is identified, claims must be voided by the provider when one of the following occurs:

   a) There are no time sheets for staff, records of attendance that demonstrate that an individual was present, or other documentation that substantiates that the individual received the service that was billed.

   b) The activity was not eligible for payment. This could include, but is not limited to the following examples:
   - Residential Habilitation services were billed for the duration of an individual's stay in a nursing facility. Residential Habilitation services can only be billed on the day of the individual's discharge from the nursing facility.
   - when the individual was admitted into the hospital.
   - Two services, which may not be provided at the same time, were delivered or billed simultaneously (such as home and community habilitation and companion services).
   - Services were provided more often than the frequency identified in the approved ISP.
   - A Community Participation Support provider bills consistently for the same number of units every week even though the provider was closed for a holiday or inclement weather.
   - A service note is entered by a Supports Coordinator as "billable" for the provision of transportation to a medical appointment.

   c) The person providing the service is not qualified to provide the service on the date it was rendered.

2. Claims may need to be adjusted if the units documented are less than the units billed and paid. For example, time sheets and documentation indicate that the support worker was present for 4 hours (16 units) but 6 hours (24 units) were billed.

If issues with claims are discovered, the provider will be notified in writing. In addition to voiding or adjusting claims, the provider shall develop and implement a corrective action

[12] In accordance with 55 Pa. Code § 6100.804(b), this section of the bulletin does not apply to base-funding only services.

plan in accordance with 55 Pa. Code §§ 6100.42(e) and 42(h) (relating to monitoring compliance). In the development of this plan, the provider should conduct a review of agency policies, procedures and forms to determine if changes are needed in addition to considering other improvement strategies such as staff training. The completed corrective action plan shall be accompanied by a list of the affected claims internal control numbers (ICNs).

Please note that auditors and monitoring staff can use statistically valid random sampling and extrapolate the results of their testing over the universe of claims. When this is done, the individual claims will not be voided or adjusted, and the extrapolated amount will be considered for recovery purposes.

Providers are encouraged to review and consider using the Medical Assistance Provider Self Audit Protocol to proactively identify and address any claim documentation related problems. The protocol can be found at: https://www.dhs.pa.gov/about/Fraud-And-Abuse/Pages/MA-Provider-Self-Audit-Protocol.aspx

ATTACHMENTS:

Attachment 1, *Technical Guidance for Claim and Service Documentation for providers and Supports Coordination Organization of Consolidated, Community Living, and Person/Family Directed Support Waiver services as well as Targeted Support Management (TSM) and Base-funded Services.*

Attachment 2, *Technical Guidance for Claim and Service Documentation for providers of services in the Adult Autism Waiver*

OBSOLETE DOCUMENTS:

Bulletin 00-17-02, *Claim and Service Documentation Requirements for Providers of Consolidated and Person/Family Directed Support Waiver Services and Targeted Services Management*

Bulletin 00-18-04, *Interim Technical Guidance for Claim and Service Documentation*

Bureau of Autism Services Communication #BAW18-20, *REISSUE and CLARIFICATION: Definition of Billable Units under the Adult Autism Waiver*

ODP Announcement 19-089, *Clarifying the Requirement for the Master Provider Index Number for Claim and Service Documentation*